

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155115		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/16/2012	
NAME OF PROVIDER OR SUPPLIER  CARDINAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
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F0000	<p>This visit was for the Investigation of Complaint IN00103832</p> <p>Complaint IN00103832 Substantiated. Federal/State deficiencies related to the allegation are cited at F244, F279, F323 and F353</p> <p>Survey date: February 16, 2012</p> <p>Facility number: 000048 Provider number: 155115 AIM number: 100275330</p> <p>Survey team: Sandra Haws, RN</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 10 Medicaid: 77 Other: 23 Total: 110</p> <p>Sample: 6</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p>			F0000	<p><b>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</b></p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012

FORM APPROVED

OMB NO. 0938-0391

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	Quality review completed 2/22/12 Cathy Emswiller RN						

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F0244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on observation, record review and interview, the facility failed to ensure resident's grievances were addressed in a timely manner related to weekly resident council interviews that had been conducted, repeated the same complaints and concerns about care and call lights every week with no evidence of the grievances being addressed or fixed affecting 2 of 6 sampled residents, resulting in the resident being in a urine soaked bed for 2 hours (Resident # H) and one resident (Resident J) yelling for help for 5 minutes. This deficient practice had the potential to affect 17 of 17 residents who expressed concerns during the resident council meetings. [Residents K, M, U, L, T, I, Y, O, N, P, Q, R, S, V, W, AND Z]</p> <p>Findings include:</p> <p>During an interview with CNA # 3 on 2/16/12 at 4:15 a.m. she indicated she works alone with 47 to 49 residents most of the time. She indicated when she comes to work at 10:00 p.m. there's just</p>		F0244	<p><b>F244 – Listen Act on Group Grievance/Recommendation</b> It is the practice of this provider to listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. <b><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></b></p> <p>As validated by residents # K #L, #M, #N, #O, #P, #Q, #R, #S, #T, #U, # V and #Y and by unanimous positive affirmation as recorded in the resident council minutes dated 03/20/2011, call lights are being answered in a much improved and satisfactory manner and CNAs are following through after answering their respective call lights.</p> <p>In interviews with residents #L, #Q, #Y, #T, #O, staff members are not perceived as being rude on weekends.</p> <p>In interviews with residents #Z, #L, #T, #H, #I and #O, staff members are not perceived as providing poor care while bathing (bed baths) – nor</p>		03/17/2012	

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	<p>her and the nurse scheduled on the 1st floor. CNA # 3 indicated sometimes they have an extra person come in at 4:00 a.m. to help with getting people up. She further indicated when she comes to work at 10:00 p.m. the call lights are going off frequently and many of the residents are 2 person assist for care and transfers and they can't get to the other residents on time and they fall or wet themselves. CNA # 3 and LPN # 5 both indicated residents have fallen because there wasn't enough staff to assist them on time.</p> <p>During observation on 2/16/12 at 4:40 a.m., a resident (Resident # J) was observed sitting up on the edge of her bed screaming for help. CNA # 3 and LPN # 5 were observed busy in other resident rooms. After 5 minutes, CNA # 3 heard the screaming resident and ran out of the resident's room to assist the screaming resident before she fell. CNA # 3 indicated if she hadn't been close enough to hear her, she would have fallen out of her bed. CNA # 3 indicated she's not able to get to some call lights for up to 2 hours when they are going off on the other halls.</p> <p>Review of the Resident Council meeting minutes on 2/16/12 at 9:45 a.m. indicated some of the following concerns:,</p> <p>Resident Council minutes dating January</p>		<p>using cold washcloths, nor drying residents improperly, nor poorly squeezing excess water out of washcloths (getting bed wet). Interviewed residents stated they are being changed in a timely manner.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> Any resident with a grievance or concern has the potential to be affected by this finding. A review of the facility Resident/Family Concern/Grievance Log as well as Resident Council minutes will be completed. This review will ensure all grievances/concerns have been addressed and/or resolved and communicated to the person initiating the grievance. The ED/designee is responsible for completing this review. Any unresolved grievances/concerns will be followed up with at the time noted. In addition, the facility will conduct weekly Resident Council meetings in order to ensure prompt feedback and follow up from any verbalized concerns. Residents with grievances/concerns will be queried regarding their satisfaction to the resolution.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient</b></p>				

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	<p>3, 2012 with 10 residents signed attending (Residents # K, # L, # M, # N, # O, # P, # Q, # R, # S and # T) indicated the "...call lights not being answered, CNA's don't follow through after answering call light...."</p> <p>January 10, 2012 with 7 residents signed attending (Residents # O, # U, # N, # M, # T, # V, and # L) indicated "...call light issues (taking long to answer)...."</p> <p>January 17th, 2012 with 10 residents signed attending ( Residents # O, # L, # U, # K, # Q, # T, # W, # N, # X and # S) indicated "... (Resident name) waits hours before call light is answered...."</p> <p>January 24, 2012 with 6 residents signed attending (Residents # L, # Q, # Y, # T, # O, and # U) indicated "...call lights still not getting answered timely...weekend staff is rude..."</p> <p>January 31, 2012 with 7 residents signed attending (Residents # Z, # L, # T, # H, # I, # U and # O) indicated "...poor care by CNA's while bathing (bed baths)- cold rags, don't dry them good, doesn't squeeze excess water out of rag (gets bed wet), (Resident name) was wet from 8 p.m. until after 10 p.m. before being changed."</p> <p>February 7, 2012 with 3 residents signed</p>		<p><b>practice does not recur:</b> A mandatory all staff in-service will be conducted on 3/6/12. This in-service will include review of the facility policy titled, "Resident/Family Grievances and Concerns". This in-service will include review of the process for resolution of grievances and concerns as well as prompt and timely response to all resident and family concerns. The ED/designee is responsible for conducting this in-service. In addition, the facility will conduct weekly Resident Council Meetings in order to ensure prompt feedback and follow up from any verbalized concerns or grievances. Residents with grievances/concerns will be queried regarding their satisfaction to the resolution. Staff re-education with return demonstrations where applicable and call light response audits/monitoring are being utilized to correct the alleged deficient practice. Department managers and/or designees on random shifts and times will complete audit tools and will audit resident concerns.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> To ensure ongoing compliance with this corrective action, the ED/designee will be responsible</p>				

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	<p>attending (Residents # U, # Y and # O) indicated "...2nd shift very slow!...poor quality of care on weekends, call lights still not answered timely."</p> <p>February 14, 2012 with 4 residents signed attending ( Residents # M, # H, # U and # L) indicated "...3 a.m. (Resident name) had call light on to go to bathroom; she wet on herself, her bed got changed, but she did not get cleaned up...CNA's not using bath basin when giving bed baths, call lights still on too long, (Resident name) can't get any help in a.m. with bedpan, (Resident name) yells for help and no one answers for 1/2 hour, not enough care given last weekend, (Resident name) wet, (CNA name) checked on her twice, never changed her or got her CNA (took about 1 hour before getting changed.)"</p> <p>During an interview with the Administrator on 2/16/12 at 9:40 a.m. regarding the weekly resident concerns, he indicated he was working on them, but was not able to provide any documentation or plan for fixing the ongoing problems.</p> <p>During an interview with alert and oriented Resident # H on 2/16/12 at 10:30 a.m. regarding her care at night, she made the following statement; " Last week one</p>		<p>for completion of the CQI Audit Tool titled, "Grievance Resolution". This tool will be completed daily for 4 weeks and then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.<b>By what date the systemic changes will be completed:</b> Compliance Date = 3/17/12.</p>				

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	<p>night I turned my call light on, they never came in for over an hour, I had to pee very bad. I hollered and yelled for help and they never came in. I have no legs so I can't help myself. I had to pee in my bed and lay in it for 2 hours When they finally came in to wash me off, they was in a hurry, so they put some soap on a rag and rubbed it over me and then dried me off never using a basin of water."</p> <p>Resident # H stated she called the hot line to report the poor care and lack of staff. She further indicated when she has complained to management, they just tell her they are hiring people but stated in the mean time she's not taken care of. She indicated the weekends are just as bad, the call lights are never answered.</p> <p>This Federal tag relates to Complaint # IN00103832.</p> <p>3.1-3(l)</p>						

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure resident's plan of care had been updated after the resident's fell, related to the residents experiencing falls without the plan of care updated for 2 of 6 resident's reviewed with care plans in a sample of 6. Resident # F and # G</p> <p>Findings include:</p> <p>1. Resident # F's record was reviewed on 2/16/12 at 6:00 a.m. The resident's record indicated diagnoses of, but not limited to; Osteoarthritis, dementia and a disorder of</p>		F0279	<p><b><u>F279 – Comprehensive Care Plans</u></b> It is the practice of this provider to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. <b><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident F – care plan has been reviewed and updated to reflect her current status related to safety and falls prevention. This resident experienced no negative outcome as a result of this finding. Resident G – care plan has been</i></b></p>		03/17/2012	

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	<p>the bone and cartilage.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 12/2/11 indicated her cognition was moderately impaired, she was total assistance with 2 or more staff for transfers, ambulation, eating, and bathing. The MDS further indicated she was incontinent of both bowel and bladder function.</p> <p>The resident's record indicated she had fallen on 2/09/12 at 4:15 a.m. A nurses note documented on 2/9/12 at 4: 28 a.m. indicated " resident found on floor beside bed on mat, no injury noted, neuro checks started wnl (within normal limits) vs (vital signs) wnl, no signs of pain or discomfort from fall, will have days locate bed alarm to be put in place to help prevent further falls."</p> <p>The resident's plan of care dated 2/2/12 indicated "Problem; Resident is at risk for fall due to: poor physical functioning, aging, hx (history of ) falls..." The plan of care failed to include the bed alarm.</p> <p>During an interview with the MDS coordinator # 4, on 2/16/12 at 8:00 a.m. she indicated the alarm was noted in the IDT (interdisciplinary team) notes and not the plan of care.</p>			<p>reviewed and updated to reflect her current status related to safety and falls prevention. This resident experienced no negative outcome as a result of this finding.<b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents who experience a fall have the potential to be affected by this finding. A facility audit will be conducted by the Nurse Management Team. This audit will review all fall care plans for those residents with falls dating back to 1/1/12. The audit will ensure that these residents have accurate and updated care plans and that fall care plans have been updated with a new intervention post fall. Any discrepancies will be clarified and corrected at the time noted. In addition, the IDT will review falls during daily clinical meetings to ensure appropriate interventions were initiated post fall and to ensure care plans and Nurse Aide Assignment Sheets have been updated accordingly. The on-call nurse will be notified promptly after any fall event to ensure appropriate interventions are initiated. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> A nursing in-service will be</p>			

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	<p>IDT note dated 2/13/12 at 10:53 a.m. indicated the resident was found on the floor again and received a skin tear to her right hand and a hematoma to her forehead. The resident had been sent to the emergency room for an evaluation following the fall. The plan of care failed to include an update for the 2/11/12 fall.</p> <p>2. Resident G's record was reviewed on 2/16/12 at 7:00 a.m. The resident's record indicated diagnoses of, but not limited to; Uncontrolled diabetes, obesity, kidney disease, and cerebral vascular accident.</p> <p>The resident's MDS indicated her cognition was moderately impaired and needed extensive assistance with bed mobility and 2 staff. The resident needed extensive assistance with transfers and dressing and was incontinent of bowel and bladder function.</p> <p>The resident's record indicated she had an unwitnessed fall on 2/7/12 at 10:45 p.m. Nurse note dated 2/8/12 at 3:00 a.m. indicated " resident was found on floor beside bed wrapped in comforter and bed sheet. Resident states when she was reaching for something on bedside table she started sliding and slid right out of bed...."</p> <p>The resident's plan of care dated 12/23/12</p>			<p>conducted by the DNS/designee on 3/6/12. This in-service will include review of the policy titled, "Fall Management Program". This in-service will also include review of the procedure related to post fall review and documentation including reviewing and updating the falls care plan and Nurse Aide Assignment Sheet promptly after any fall event. In addition, the IDT will review falls during daily clinical meetings to ensure all care plans are updated with new and appropriate interventions after any fall event. The on-call nurse will be notified promptly after any fall event to ensure appropriate interventions are initiated. Daily nursing rounds will be conducted to ensure safety interventions are in place per individual resident care plan.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>The CQI Audit tool titled, "Care Plan Updating" and will be completed weekly x 4 weeks, then monthly for 6 months by the MDS Coordinator/designee. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>Daily rounds will be conducted on all shifts by nurse managers or designees.</p>			

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	<p>indicated "Problem, Resident is at risk for fall due to impaired mobility, incontinence, Dx (diagnosis) Hx of CVA (cerebral vascular accident)...." The residents plan of care failed to indicate it had been updated to include a new intervention to prevent another fall.</p> <p>This Federal tag relates to Complaint # IN00103832</p> <p>3.1-35(a)</p>			<p><b>By what date the systemic changes will be completed:</b> Compliance Date = 3/17/12.</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to provide necessary supervision to ensure 2 residents who were at high risk for falling (Residents # F and # G) were protected from falls for 2 of 2 residents reviewed for falls in a sample of 6.</p> <p>Findings include :</p> <p>During an interview with CNA # 3 on 2/16/12 at 4:15 a.m. she indicated she works alone with 47 to 49 residents most of the time. She indicated when she comes to work at 10:00 p.m. there's just her and the nurse scheduled on the 1st floor. CNA # 3 indicated sometimes they have an extra person come in at 4:00 a.m. to help with getting people up. She further indicated when she comes to work at 10:00 p.m. the call lights are going off frequently and many of the residents are 2 person assist for care and transfers and they can't get to the other residents on time and they fall or wet themselves. CNA # 3 and LPN # 5 both indicated residents have fallen because there wasn't</p>	F0323	<p><b><u>F323 – Free of Accident Hazards/Supervision</u></b> It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistive devices to prevent accidents. <b><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident F</i></b> has experienced no further falls. A safety inspection of this resident's room has been completed by the IDT. The care plan and Nurse Aide Assignment Sheet have been reviewed and updated to reflect all current safety interventions. <b><i>Resident G</i></b> has experienced no further falls. A safety inspection of this resident's room has been completed by the IDT. The care plan and Nurse Aide Assignment Sheet have been reviewed and updated to reflect all current safety interventions. <b><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</i></b></p>		03/17/2012		

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	<p>enough staff to assist them on time. LPN # 5 indicated Resident # F and # G both have fallen during the night shift with 1 CNA scheduled.</p> <p>1. Resident # F's record was reviewed on 2/16/12 at 6:00 a.m. The resident's record indicated diagnoses of, but not limited to; Osteoarthritis, and a disorder of the bone and cartilage.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 12/2/11 indicated her cognition was moderately impaired, she was total assistance with 2 or more staff for transfers, ambulation, eating, and bathing. The MDS further indicated she was incontinent of bowel and bladder function.</p> <p>The resident's record indicated she had fallen on 2/09/12 at 4:15 a.m. A nurses' note documented on 2/9/12 at 4: 28 a.m. indicated " resident found on floor beside bed on mat, no injury noted, neuro checks started wnl (within normal limits) vs (vital signs) wnl, no signs of pain or discomfort from fall, will have days locate bed alarm to be put in place to help prevent further falls."</p> <p>The resident's plan of care dated 2/2/12 indicated "Problem; Resident is at risk for fall due to: poor physical functioning,</p>		<p><b>action(s) will be taken:</b> All residents identified as being at risk for falls have the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team. This audit will ensure that all residents identified as being at risk for falls have appropriate safety interventions in place to prevent falls and accidents. The Nurse Aide Assignment Sheets will be checked against each resident's fall care plan to ensure all safety interventions are in place. In addition, resident room safety inspections will be completed to ensure all safety interventions are in place. Fall Risk Assessments will be completed on admission, quarterly, annually and with any significant change in condition. Resident specific fall prevention interventions are initiated and communicated to all caregivers when any assessment identifies a resident at risk for falls. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> A nursing in-service will be conducted on 3/6/12. This in-service will include review of the policy titled, "Fall Management Program". This in-service will also include review of falls prevention interventions and the importance of timely response to resident call lights and careful attention to the Nurse</p>				

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	<p>aging, hx (history of ) falls..." The plan of care failed to include the bed alarm.</p> <p>During an interview with the MDS coordinator # 4, on 2/16/12 at 8:00 a.m. she indicated the alarm was noted in the IDT (interdisciplinary team) notes and not the plan of care.</p> <p>IDT note dated 2/13/12 at 10:53 a.m. indicated the resident was found on the floor again and received a skin tear to her right hand and a hematoma to her forehead. The resident had been sent to the emergency room for an evaluation following the fall. The plan of care failed to include an update for the 2/11/12 fall.</p> <p>2. Resident G's record was reviewed on 2/16/12 at 7:00 a.m. The resident's record indicated diagnoses of, but not limited to; Uncontrolled diabetes, obesity, kidney disease, and cerebral vascular accident.</p> <p>The resident's MDS indicated her cognition was moderately impaired and needed extensive assistance with bed mobility and 2 staff. The resident needed extensive assistance with transfers and dressing and was incontinent of bowel and bladder function.</p> <p>The resident's record indicated she had an unwitnessed fall on 2/7/12 at 10:45 p.m.</p>		<p>Aide Assignment Sheets to ensure all resident specific safety interventions are in place to prevent falls. Falls will be thoroughly reviewed in the daily clinical meeting to ensure appropriate interventions were initiated post fall and to ensure care plans and Nurse Aide Assignment Sheets have been updated accordingly. Daily nursing rounds will be conducted to ensure safety interventions are in place per individual resident care plan. Fall Risk Assessments will be completed on admission, quarterly, annually and with any significant change in condition. Resident specific fall prevention interventions are initiated and communicated to all caregivers when any assessment identifies a resident at risk for falls. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> To ensure ongoing compliance with this corrective action, the DNS/designee will complete the CQI Audit tool titled, "Fall Management". This tool will be completed weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Data will be submitted to the CQI Committee for review and follow up. Daily rounds will be conducted on all shifts by nurse managers or designees. <b>By what date the</b></p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>Nurse note dated 2/8/12 at 3:00 a.m. indicated " resident was found on floor beside bed wrapped in comforter and bed sheet. Resident states when she was reaching for something on bedside table she started sliding and slid right out of bed...."</p> <p>The resident's plan of care dated 12/23/10 indicated "Problem, Resident is at risk for fall due to impaired mobility, incontinence, Dx (diagnosis) Hx of CVA (cerebral vascular accident).</p> <p>During an interview with CNA # 6 on 2/16/12 at 4:30 a.m. regarding the residents who had fallen on night shift, she stated "Resident # G fell because we just couldn't get to her in time. When everybody is calling and complaining needing to use the bedpan or need water and there is only 1 CNA, they wind up waiting a long time, wetting themselves or falling."</p> <p>This Federal tag relates to Complaint # IN00103832.</p> <p>3.1-45(2)</p>		<p><b>systemic changes will be completed:</b> Compliance Date = 3/17/12.</p>				

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F0353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interviews and record review, the facility failed to ensure there was sufficient nursing staff to care for residents related to 1 nursing assistant and 1 nurse scheduled at night to care for 47 residents resulting in 2 residents who had fallen during the night shift, and for 1 resident who had to urinate in her bed and lay in it due to lack of sufficient staff, and 1 resident observed yelling for help for 5 minutes. This deficient practice had the potential to affect 4 of 6 residents in sample of 6. Residents # F, # G, # J and # H</p>			F0353	<p><b><u>F353 – Sufficient 24-Hour Staff Per Care Plans</u></b></p> <p>It is the practice of this provider to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p><b><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></b></p> <p><i>Resident F – care plan has been reviewed and updated to reflect her</i></p>		03/17/2012

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	<p>Findings include:</p> <p>During a night shift tour of the facility on 2/16/12 at 3:50 a.m. accompanied by LPN # 5, he indicated there were 2 CNA's on the schedule for this night shift, but most of the time he works with only 1 CNA for 47 to 49 residents. LPN # 5 indicated they do their best, but care does suffer because there's not enough staff to care for this many residents.</p> <p>During a continued interview with LPN # 5, he indicated he has been working on the 1st floor for almost a month with 1 aide, and indicated it has become the normal, rarely are there 2 aides and there has been 47 to 48 residents.</p> <p>During an interview with CNA # 3 on 2/16/12 at 4:15 a.m. she indicated she works alone with 47 to 49 residents most of the time. She indicated when she comes to work at 10:00 p.m. there's just her and the nurse scheduled on the 1st floor. CNA # 3 indicated sometimes they have an extra person come in at 4:00 a.m. to help with getting people up. She further indicated when she comes to work at 10:00 p.m. the call lights are going off frequently and many of the residents are 2 person assist for care and transfers and they can't get to the other residents on time and they fall or wet themselves.</p>		<p>current status related to safety and falls prevention. This resident experienced no negative outcome as a result of this finding. There is adequate staff to provide necessary care and services to this resident.</p> <p><i>Resident G</i> - care plan has been reviewed and updated to reflect her current status related to safety and falls prevention. This resident experienced no negative outcome as a result of this finding. There is adequate staff to provide necessary care and services to this resident.</p> <p><i>Resident J</i> - experienced no negative outcome as a result of this finding. There is adequate staff to provide necessary care and services to this resident.</p> <p><i>Resident H</i> - experienced no negative outcome as a result of this finding. There is adequate staff to provide necessary care and services to this resident.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected by this finding. Nursing schedules and staffing ratios are reviewed daily. The DNS/designee is responsible for ensuring adequate and sufficient nursing staff to provide care to all residents.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the</b></p>				

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	<p>CNA # 3 and LPN # 5 both indicated residents have fallen because there wasn't enough staff to assist them on time. LPN # 5 indicated Resident # F and # G both have fallen during the night shift with 1 CNA scheduled.</p> <p>Continued interview with CNA # 3 regarding working alone with 47 to 49 residents she indicated there are 3 different halls on the 1st floor and she's not able to assist everyone in a reasonable time. CNA # 3 indicated the nurse helps when they're able to, but they have their job to do and can't always help out.</p> <p>1. During observation on 2/16/12 at 4:40 a.m. a resident ( Resident # J) was observed sitting up on the edge of her bed screaming for help. CNA # 3 and LPN # 5 were observed busy in other resident rooms. After 5 minutes, CNA # 3 heard the screaming resident and ran out of the resident's room to assist the screaming resident before she fell. CNA # 3 indicated if she hadn't been close enough to hear her, she would have fallen out of her bed. CNA # 3 indicated she's not able to get to some call lights for up to 2 hours when they are going off on the other halls.</p> <p>2. Resident # F's record was reviewed on 2/16/12 at 6:00 a.m. The resident's record indicated diagnoses of, but not limited to;</p>		<p><b>deficient practice does not recur:</b> A nursing in-service is scheduled for 3/6/12. The ED/DNS/designee is responsible for conducting this in-service. This in-service will include review of staffing patterns and required staffing ratios to provide nursing and related services to all residents. The charge nurses will be instructed to contact the on-call nurse in the event that there is a change in the scheduled staffing for any shift. The on-call nurse rotation will ensure sufficient staffing and adequate coverage at all times. The nurse management team will provide direct care coverage if needed in order to ensure sufficient staffing coverage. The Nurse Management Team will meet daily to review staffing/scheduling to ensure adequate coverage.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit tool titled, "Staffing Patterns/Scheduling" daily for 4 weeks then 3 times weekly for 6 months. If threshold of 100% is not met, an action plan will be developed.</p> <p><b>By what date the systemic changes will be completed:</b> Compliance Date = 3/17/12.</p>				

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	<p>Osteoarthritis, and a disorder of the bone and cartilage.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 12/2/11 indicated her cognition was moderately impaired, she was total assistance with 2 or more staff for transfers,, ambulation, eating, and bathing. The MDS further indicated she was incontinent of bowel and bladder function.</p> <p>The resident's record indicated she had fallen on 2/09/12 at 4:15 a.m. A nurses note documented on 2/9/12 at 4: 28 a.m. indicated " resident found on floor beside bed on mat, no injury noted, neuro checks started wnl (within normal limits) vs (vital signs) wnl, no signs of pain or discomfort from fall, will have days locate bed alarm to be put in place to help prevent further falls."</p> <p>The resident's plan of care dated 2/2/12 indicated "Problem; Resident is at risk for fall due to: poor physical functioning, aging, hx (history of ) falls..." The plan of care failed to include the bed alarm.</p> <p>During an interview with the MDS coordinator # 4, on 2/16/12 at 8:00 a.m. she indicated the alarm was noted in the IDT (interdisciplinary team) notes and not the plan of care.</p>						

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	<p>IDT note dated 2/13/12 at 10:53 a.m. indicated the resident was found on the floor again and received a skin tear to her right hand and a hematoma to her forehead. The resident had been sent to the emergency room for an evaluation following the fall. The plan of care failed to include an update for the 2/11/12 fall.</p> <p>3. Resident G's record was reviewed on 2/16/12 at 7:00 a.m. The resident's record indicated diagnoses of, but not limited to; Uncontrolled diabetes, obesity, kidney disease, and cerebral vascular accident.</p> <p>The resident's MDS indicated her cognition was moderately impaired and needed extensive assistance with bed mobility and 2 staff. The resident needed extensive assistance with transfers and dressing and was incontinent of bowel and bladder function.</p> <p>The resident's record indicated she had an unwitnessed fall on 2/7/12 at 10:45 p.m. Nurse note dated 2/8/12 at 3:00 a.m. indicated " resident was found on floor beside bed wrapped in comforter and bed sheet. Resident states when she was reaching for something on bedside table she started sliding and slid right out of bed...."</p>						

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	<p>The resident's plan of care dated 12/23/10 indicated "Problem, Resident is at risk for fall due to impaired mobility, incontinence, Dx (diagnosis) Hx of CVA (cerebral vascular accident).</p> <p>During an interview with CNA # 6 on 2/16/12 at 4:30 a.m. regarding the residents who had fallen on night shift, she stated "Resident # G fell because we just couldn't get to her in time. When everybody is calling and complaining needing to use the bedpan or need water and there is only 1 CNA, they wind up waiting a long time, wetting themselves or falling." CNA # 6 indicated they have complained to management but all they say is they're working on it.</p> <p>Review of the facility staffing schedule on 2/16/12 at 9:45 a.m. indicated on the following night shifts on the 1st floor indicating only 1 nurse and 1 CNA scheduled:</p> <p>January 1st 10 p.m. until 2:00 a.m. for 49 residents January 5th-10 p.m. until 4:00 a.m. for 46 residents January 10th-10 p.m. until 4:00 a.m. for 47 residents January 11th-10 p.m. until 4:00 a.m. for 47 residents January 14th-10 p.m. until 4:00 a.m. for</p>						

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	<p>47 residents January 15th- 2 a.m. until 4:00 a.m. for 48 residents January 16th- 2 a.m. until 4:00 a.m. for 47 residents January 20th- 10 p.m. until 4:00 a.m. for 48 residents January 21st- 10 p.m. until 2:00 a.m. for 48 residents January 22nd- 10 p.m. until 4:00 a.m. for 48 residents January 23rd- 10 p.m. until 4:00 a.m. for 48 residents January 24th- 10 p.m. until 4:00 a.m. for 47 residents January 30th- 10 p.m. until 4:00 a.m. for 46 residents January 31st- 10 p.m. until 4:00 a.m. for 45 residents</p> <p>For the month of February 2012 the following night shifts on the 1st floor indicated there was only 1 nurse and 1 CNA scheduled;</p> <p>February 2nd from 10 p.m. until 4:00 a.m. for 48 residents February 4th from 10 p.m. until 4:00 a.m. for 47 residents February 7th from 10 p.m. until 2:00 a.m. for 47 residents February 8th from 10 p.m. until 4:00 a.m. for 47 residents February 9th from 10 p.m. until 4:00 a.m.</p>						

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	<p>for 48 residents February 10th from 10 p.m. until 4:00 a.m. for 48 residents February 12th from 10 p.m. until 4:00 a.m. for 46 residents February 13th from 10 p.m. until 4:00 a.m. for 46 residents February 14th from 10 p.m. until 4:00 a.m. 46 residents</p> <p>During an interview with the staff responsible for scheduling the shifts on 2/16/12 at 10:00 a.m. she indicated there should be 2 CNA's and a nurse scheduled for night shift and when we can't we try and have a CNA come in at 4:00 a.m. but it still leaves the floor with only 1 nurse and 1 CNA from 10 p.m. until 4:00 a.m.</p> <p>During an interview with the Administrator on 2/16/12 at 10:10 a.m. regarding the lack of sufficient staff for 48 residents being unsafe he indicated he agreed that there should have been 2 CNA's for that many residents.</p> <p>4. During an interview with alert and oriented Resident # H on 2/16/12 at 10:30 a.m. regarding her care at night, she made the following statement; " Last week one night I turned my call light on, they never came in for over an hour, I had to pee very bad. I hollered and yelled for help and they never came in. I have no legs so</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155115		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/16/2012	
NAME OF PROVIDER OR SUPPLIER  CARDINAL NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN 46617			
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	<p>I can't help myself. I had to pee in my bed and lay in it for 2 hours. When they finally came in to wash me off, they was in a hurry, so they put some soap on a rag and rubbed it over me and then dried me off never using a basin of water."</p> <p>Resident # H stated she called the hot line to report the poor care and lack of staff. She further indicated when she has complained to management, they just tell her they are hiring people but stated in the mean time she's not taken care of. She indicated the weekends are just as bad, the call lights are never answered.</p> <p>This Federal tag relates to Complaint # IN00103832.</p> <p>3.1-17(a) 3.1-17(b)</p>						

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